The Florida Senate

Interim Report 2010-120 *January 2010*

Committee on Health Regulation

SUPPLEMENTAL MEDICAID PAYMENTS

Issue Description

In addition to the standard direct reimbursement to health care providers, most state Medicaid programs make supplemental payments, payments separate from and in addition to those made at a state's standard Medicaid payment rate, to certain providers.[1] Florida has supplemental funding programs for hospitals, physicians, and other Medicaid providers to ensure access to hospital inpatient and specialty care by more than 2.7 million Medicaid recipients[2] and access to Florida's safety-net hospitals for the over 3.6 million uninsured.[3]

Chapter 2005-133, Laws of Florida, authorized the Agency for Health Care Administration (Agency) to apply for a Medicaid managed care reform waiver that included changes to the Medicaid supplemental funding programs for hospitals. This waiver is scheduled to expire June 30, 2011. A significant portion of Florida supplemental Medicaid payments is tied to the Medicaid reform waiver. The 2010 Legislature will need to decide whether to phase out the Medicaid reform waiver or authorize the Agency to seek an extension or renewal of the waiver. An important consideration in this decision is how to maintain supplemental payments.

Background

Florida Medicaid Program

Florida implemented its Medicaid program on January 1, 1970, to provide medical services to indigent people. Florida's Medicaid program is jointly funded by federal, state, and county governments to provide medical care to eligible individuals. The Agency for Health Care Administration (Agency) is the single state agency responsible for the Florida Medicaid program. The statutory provisions for the Medicaid program appear in ss. 409.901 through 409.9205, F.S.

The Florida Medicaid program has over 2.7 million people enrolled.[4] Florida expects to spend more than $18 billion on its Medicaid program in FY 2009-2010.[5] Over 1 million Medicaid recipients are enrolled in Medicaid health maintenance organizations (HMOs), and approximately two-thirds of all Medicaid recipients are enrolled in some type of Medicaid managed care.[6]

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[1] United States Government Accountability Office, GAO-08-614, Medicaid – CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments, May 2008. Found at: <http://www.gao.gov/new.items/d08614.pdf> (Last visited January 15, 2010).

[2] Agency for Health Care Administration, Medicaid Eligibles Report, September 30, 2009. Found at: <http://www.fdhc.state.fl.us/Medicaid/about/pdf/age_assistance_category_091015.pdf> (Last visited January 15, 2010).

[3] U.S. Census Bureau, Current Population Survey, Health Insurance Coverage Status by State for All People: 2008. Found at: <http://www.census.gov/hhes/www/cpstables/032009/health/h06_000.htm> (Last visited January 15, 2010).

[4] Agency for Health Care Administration, Reports of Medicaid Eligibles, By Age By County, 11/30/2009. Found at: <http://Agency.myflorida.com/Medicaid/about/pdf/age_cnty_091210.pdf> (Last visited January 15, 2010).

[5] Agency for Health Care Administration, Presentation to the Senate Health and Human Services Appropriations Committee meeting November 18, 2009. Found online at: <http://Agency.myflorida.com/Medicaid/deputy_secretary/recent_presentations/medical_home_tf/2009-11-18/mht_national_health_care_reform_proposal_overview_111809.pdf>. Last visited January 15, 2010).

[6] Comprehensive Medicaid Managed Care Report, December 2009. Found at: <http://Agency.myflorida.com/MCHQ/Managed_Health_Care/MHMO/med_data.shtml> (Last visited January 15, 2010).

The Federal Government is the largest source of funding for medical assistance expenditures in the Florida Medicaid program. This federal share, known as the Federal Medical Assistance Percentage (FMAP), is based on the ratio of state per capita income to the national per capita income and is calculated annually. The current Florida FMAP for FY 2009-2010 is 67.64 percent.[7] The current FMAP provides a uniquely high amount of federal funding because enhanced FMAP funds were part of the American Recovery and Reinvestment Act of 2009. The FMAP and the state match are the primary sources of funding for the Florida Medicaid program.

Pursuant to s. 409.908, F.S., reimbursement methodologies for Medicaid providers vary by type of provider. Medicaid provider rates are set forth in Agency rules, policy manuals, and Medicaid provider handbooks. Medicaid provider payment methodologies include: fee schedules, reimbursement methods based on cost reporting, negotiated fees, competitive bidding, and other methods the Agency considers efficient and effective for purchasing services or goods on behalf of recipients. Medicaid reimbursement is subject to any limitations or directions provided for in the General Appropriations Act (GAA).

In addition to standard direct reimbursement to health care providers for services provided, most state Medicaid programs make supplemental payments, payments separate from and in addition to those made at a state's standard Medicaid payment rate, to certain providers. The supplemental funding programs currently operating in the Florida Medicaid program are the Disproportionate Share Hospital (DSH) program, Low Income Pool (LIP) program, and a supplemental physician payment program.[8] Florida has a statutorily created LIP Council that makes yearly recommendations to the Governor and the Legislature on the allocation of supplemental Medicaid payments to hospitals and other providers. Ultimately the Legislature maintains the final authority to allocate supplemental Medicaid payments to hospitals and other providers in the GAA.

Historically, Florida used to operate a DSH program and an upper payment limit (UPL) program to provide supplemental payments to Medicaid providers. The Medicaid supplemental payment system was substantially reformed during the 2005 Legislative Session when the Legislature authorized the Agency to apply for a Medicaid reform waiver.

Florida law also authorizes rate buy-backs and exemptions to supplement current Medicaid rates. For the purposes of this project, buy-backs and exemptions are not included in the supplemental Medicaid payments discussion.

History of Supplemental Medicaid Payments

Disproportionate Share Hospital Program

In the early 1980s, Congress established the Medicaid DSH program to provide financial relief to hospitals serving the poor.[9] The program was designed to improve the financial stability of hospitals that serve a "disproportionate share of low-income patients." Federal law mandates that states make DSH payments to certain hospitals with high Medicaid or low-income inpatient use rates.[10] States had broad authority to decide which hospitals qualify for DSH payments and to set payment levels for those hospitals. However, by 1985, only 17 states had implemented DSH programs.[11]

In 1985, the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services) ruled that states could use hospital taxes and donations to fund the nonfederal share of Medicaid DSH payments.[12] This allowed

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[7] The current FMAP for Florida includes the federal FMAP stimulus enhancement.
[8] The supplemental physician payment program is also known as physician upper payment limit (UPL).
[9] See the Omnibus Budget Reconciliation Act of 1981. Found at: <http://www.ssa.gov/OP_Home/comp2/F097-035.html> (Last visited January 15, 2010).
[10] Teresa A. Coughlin, Brian K. Bruen, and Jennifer King, *States' Use of Medicaid UPL And DSH Financing Mechanisms*, Health Affairs, Volume 23, Number 2, March/April 2004. Found at: <http://content.healthaffairs.org/cgi/reprint/23/2/245> (Last visited January 15, 2010).
[11] Rober E. Mechanic, Consultant, National Health Policy Forum, Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments, September 14, 2004. Found at: <http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf> (Last visited January 15, 2010).
[12] Robert E. Mechanic, Consultant, National Health Policy Forum, Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments, September 14, 2004. Found at: <http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf> (Last visited January 15, 2010).

states to draw down additional funds from the federal government without having to appropriate additional general revenue. These funds are known as intergovernmental transfers or IGTs.

In the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987), Congress established national definitions for DSH hospitals and required states to make payments to these facilities.[13] The definition included hospitals with:

- A Medicaid utilization rate of one standard deviation or more above the mean Medicaid utilization rate in the state; or
- A low-income utilization rate of 25 percent or more.

However, states were still allowed to designate additional DSH-eligible hospitals and set reimbursement levels. In addition the federal government did not set any limits on the amount of state DSH payments eligible for matching funds.

States capitalized on the DSH program in the late 1980s and early 1990s. Stories that states were inappropriately using DSH funds and the exponential growth in DSH payments raised concerns in the federal government. Federal officials were most concerned by reports that some states had diverted federal Medicaid funds for unrelated purposes.[14] To address problems with the DSH program, Congress has enacted legislation on several occasions since the early 1990s to increase the regulatory oversight of the DSH program and to cap annual state DSH allotments.

Under federal law, states are required to make DSH payments to hospitals that treat large numbers of low-income and Medicaid patients.[15] States' DSH programs are subject to annual caps on the amount of DSH payments a state may make, as well as the DSH payments an individual hospital may receive. The Federal DSH allotment for Florida, for FY 2009-2010 is $200,817,344.[16] The Florida DSH programs are codified in law in ss. 409.911 – 409.9119, F.S.

Hospital Upper-Payment-Limit Program

The Hospital Upper Payment Limit (UPL) program is a supplemental payment mechanism based upon an interpretation of federal Medicaid regulations[17] that allows states to make special Medicaid payments to compensate certain providers to make up the difference between Medicaid and Medicare payments for hospital services. The UPL program does not exist explicitly in law but has evolved through the interpretation of the Federal law that states that Medicaid providers cannot make payments in excess of what, "would have been paid under Medicare principles." The UPL program provides that Medicare reimbursement rates are the "upper-payment-limit" for Medicaid providers. In addition, the UPL program allows states to make additional payments to Medicaid hospitals not to exceed Medicare rates.

Medicaid DSH payments are excluded from UPL calculations.[18] State UPL programs also utilize IGTs to draw down funds from the federal government without appropriating additional state general revenue.

Federal law specifies that UPL calculations must only rely on services utilized by Medicaid beneficiaries that are paid on a fee-for-service basis.[19] Services provided to Medicaid beneficiaries in a managed care environment on a capitated basis cannot be counted for UPL payments. Thus, the structure of the UPL program prohibits hospitals from access to UPL payments for services provided to Medicaid patients enrolled in managed care plans.[20]

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[13] Omnibus Budget Reconciliation Act of 1987, Found at: <http://www.ssa.gov/OP_Home/comp2/F100-203.html> (Last visited January 6, 2010).

[14] Robert E. Mechanic, Consultant, National Health Policy Forum, Medicaid's Disproportionate Share Hospital Program: Complex Structure, Critical Payments, September 14, 2004. Found at: <http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf> (Last visited January 15, 2010).

[15] 42 U.S.C. 1396a and 1396r-4.

[16] U.S. Department of Health and Human Services, Disproportionate Share Hospitals Allotments for FY 2009. Found at: http://www.hhs.gov/recovery/cms/dshstates.html (Last visited January 15, 2010).

[17] 42 CFR 447.272.

[18] Teresa A. Coughlin, Brian K. Bruen, and Jennifer King, *States' Use of Medicaid UPL And DSH Financing Mechanisms*, Health Affairs, Volume 23, Number 2, 2004. Found at: <http://content.healthaffairs.org/cgi/reprint/23/2/245> (Last visited January 15, 2010).

[19] 42 CFR 438.60

[20] Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion, The Lewin Group, November 13, 2006. Found at: <http://www.lewin.com/content/publications/UPL.pdf> (Last visited January 15, 2010).

Florida operated a UPL program in the past. The Medicaid managed care reform waiver, authorized for implementation during the Legislature's 2005 Special Session B in HB 3-B, replaced the UPL program with a different supplemental payment program, the LIP.

Intergovernmental Transfers

As mentioned previously, IGTs are the transfer of public funds between governmental entities. A common feature in state financing of state Medicaid programs, IGTs leverage the state's ability to draw down additional federal funds. IGTs are a way for the state to fund the non-federal share of Medicaid expenditures, i.e., the state match requirements.

Historically, IGTs have been used for several reasons, including to:

- Continue the traditional role of local governments in providing indigent care;
- Offset the lack of state funding to fully fund Medicaid supplemental payments;
- Enhance access to safety-net providers; and
- Leverage local health care dollars as match for federal funds.

Section 409.908, F.S., authorizes the Agency to receive funds from other state entities, including local governments and other local political subdivisions to make Medicaid payments. The supplemental Medicaid payment programs in Florida rely more and more on the use of IGTs. Funding sources used for IGTs in Florida include: taxes raised through special referendums, ad valorem taxes, and a local sales tax. Florida counties negotiate an agreement with the Agency to contribute a specific amount of IGTs.

Not all counties donate IGTs to fund the LIP program and the DSH program. The majority of IGTs are generated by a few large urban counties (Miami/Dade, Broward, Duval, Orange, and Hillsborough).[21] However, the IGT funds donated are used on a statewide basis.

Historically, the Legislature has provided donor counties with an incentive to participate. As an incentive to donate funds, counties receive a kind of premium returned to qualifying hospitals within their counties. This incentive or "allocation factor" has fluctuated between 15-20 percent and is trending downward.

Supplemental Physician Payments

Supplemental payments to Medicaid physicians are authorized indirectly by Federal law.[22] Before Florida embarked on Medicaid reform, these payments were referred to as physician Upper Payment Limit (UPL), but are now generally referred to as Special Medicaid Payments (SMPs). These payments were developed by Florida to ensure Medicaid recipient access to specialty care at the state's medical schools.

The Florida Medicaid state plan[23] authorizes the Agency to provide for supplemental payments for services provided by doctors of medicine and osteopathy employed by or under contract with either:

- A medical school that is part of the public university system (Florida State University, The University of Florida, and the University of South Florida);
- A private medical school that places over 50 percent of its residents with a public hospital (The University of Miami); or
- Nova Southeastern University.

The Medicaid state plan also includes the exact reimbursement methodology for supplemental physician payments.[24]

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[21] See Table 6 in the LIP allocation tables. Found at: <http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/2009-12-02/VIa_sfy_10-11_base_mode.pdf> (last visited January 15, 2010).

[22] 42 CFR 447.304.

[23] Florida Medicaid State Plan, Attachment 4.19-B, page 28a. Found at: <http://Agency.myflorida.com/Medicaid/stateplanpdf/florida_medicaid_state_plan_part_II.pdf> (Last visited January 15, 2010).

LIP/Medicaid Reform

The LIP was established as part of the Medicaid managed care demonstration project. During the 2005 legislative session, CS/CS/SB 838 (enrolled) was passed authorizing the Agency to apply for a waiver to implement a Medicaid managed care pilot program. The waiver authority, codified in s. 409.91211, F.S., also included the creation of a LIP to replace the UPL funding mechanism for hospitals, provisions to preserve the state's ability to use IGTs, and provisions to protect the DSH program.

Pursuant to the authority provided in CS/CS/SB 838 (enrolled) the Agency received approval of the waiver application on October 19, 2005. The federally-approved waiver are accompanied by Special Terms and Conditions (numbered 11-W-00206/4) which, combined, constitute the guiding agreement between the state and the federal government on the implementation of the Medicaid reform proposal. Florida's Medicaid Reform Waiver is a 5-year demonstration, which began July 1, 2006 and runs through June 30, 2011.

The Centers for Medicare and Medicaid Services (CMS) Special Terms and Conditions (STC) document describes the details of the Medicaid Reform 1115 demonstration waiver. Section 15 of the STC describes the creation of the LIP. The LIP:

- Replaces the hospital upper payment limit (UPL) program;
- Was established to ensure continued government support for the provision of health care services to Medicaid, underinsured, and uninsured populations; and
- Is a capped annual allotment of $1 billion total computable for each year of the 5-year Medicaid demonstration period.[25]

According to the STC, funds from the LIP may be used for health care expenditures (medical care costs or premiums) that would be within the definition of medical assistance in Section 1905(a) of the Social Security Act. These health care expenditures may be incurred by the state, by hospitals, clinics, or by other provider types for uncompensated medical care costs of medical services for the uninsured and Medicaid shortfalls (after all other Title XIX payments are made). The LIP can also be used for payments for provider access systems and insurance products for such services provided to otherwise uninsured individuals, as agreed upon by the state and the federal CMS.

The STC require the state to submit a yearly Reimbursement and Funding Methodology document for LIP expenditures that includes: LIP parameters, state-authorized expenditures from the LIP and entities eligible to receive reimbursement, for CMS approval. In order for Florida to access the total annual $1 billion annual allocation of LIP funds, the STC outlines milestones that must be met by the state for each year of the Medicaid demonstration.

As part of Medicaid reform, the Agency was directed to create the Medicaid LIP Council, codified in s. 409.911(10), F.S. The Council:

- Makes recommendations on the financing and distribution of the LIP and the DSH funds;
- Advises the Agency on the development of the LIP plan required by the CMS waiver; and
- Advises the Agency on the distribution of hospital funds used to adjust inpatient hospital rates, rebase rates, or otherwise exempt hospitals from reimbursement limits as financed by IGTs.

The Council is required to submit its findings and recommendations to the Governor and Legislature each year, by February 1st.[26] Prior to the LIP Council, the DSH Council performed a similar function.

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[24] Florida Medicaid State Plan, Attachment 4.19-B, page 28a. Found at <http://Agency.myflorida.com/Medicaid/stateplanpdf/florida_medicaid_state_plan_part_II.pdf> (Last visited January 15, 2010).

[25] Agency for Health Care Administration, Centers for Medicare and Medicaid Services Special Terms and Conditions, Medicaid Reform Section 115 Demonstration, p. 24. Found at: <http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/waiver/pdfs/cms_special_terms_and_conditions.pdf> (Last visited January 15, 2010).

[26] See <http://ahca.myflorida.com/medicaid/medicaid_reform/lip/pdf/lip_council_recommendations_sfy0910_020209.pdf> for the LIP Council recommendations for FY 2009-2010. (Last visited January 15, 2010).

Before the LIP program, UPL and DSH payments went only to hospitals. Although a majority of the LIP funds continue to go to hospitals, the Medicaid reform waiver allows flexibility for supplemental Medicaid payments to flow to other Medicaid providers, such as federally qualified health centers. Florida is one of four states[27] that have restructured their supplemental Medicaid payment programs.

Another unique component of the waiver is that it authorized supplemental Medicaid payments to hospitals serving Medicaid recipients enrolled in managed care plans. This allows for the expansion of managed care in Florida without reducing Federal matching funds to providers.[28]

Medicaid Managed Care Programs

Florida operates a Medicaid managed care program through a federal 1915(b) waiver obtained from the CMS in 1991. The managed care waiver provides the state with authority to mandatorily assign eligible beneficiaries and, within specific areas of the state, limit choice to approved managed care providers.

Supplemental Medicaid payments are designed primarily to make-up the shortfall in Medicaid fee-for-service payments to hospitals. As managed care has expanded in the Medicaid program, there are less fee-for-service Medicaid payments to hospitals. It is unclear what role supplemental Medicaid payments would play, if the role of managed care in the Medicaid program is expanded. In addition, other policy proposals, such as the Medicaid medical home model may alter the role of supplemental Medicaid funding in Florida.

Medicaid managed care regulations prohibit direct payments to providers outside of capitated rates, unless the payments are for DSH or for medical education.[29] Without a waiver from CMS, the expansion of Medicaid managed care in Florida, could put the UPL program in jeopardy. However, the terms of the Medicaid reform waiver replaced the UPL program with the LIP and authorized payments to hospitals even in a managed care environment.

Findings and/or Conclusions

LIP

One significant feature of the LIP is that it authorizes supplemental Medicaid payments to non-hospital providers. In the last 3 years the LIP has been operational, supplemental funds have been allocated to federally qualified health centers, County Health Departments, and hospital-based primary care programs, in addition to hospitals. Funding initiatives have focused on primary care, emergency room diversion, disease management, poison control, and premium assistance programs in Miami-Dade and Palm Beach Counties. In state FY 2008-2009, $26.2 million was allocated for non-hospital programs and in FY 2009-2010, $51.3 million was allocated for non-hospital programs.

Year 5 LIP Funding

The lack of full Medicaid reform expansion may compromise some federal LIP funds in state FY 2010-2011. In year 5 of the demonstration, the full $1 billion federal LIP allocation is contingent on Medicaid reform operating statewide. Currently, the STC #105 specifies that $700 million will be available at the beginning of year 5 and an additional $300 million will be available at the time the demonstration is operating on a statewide basis.[30][31] The state is currently in

[27] California, Iowa, and Massachusetts have similar supplemental Medicaid payment programs authorized via federal waivers.
[28] Medicaid Upper Payment Limit Policies: Overcoming a Barrier to Managed Care Expansion, The Lewin Group, November 13, 2006. Found at: <http://www.lewin.com/content/publications/UPL.pdf> (Last visited January 15, 2010).
[29] Medicaid Section 1115 Demonstration Projects: Financing Opportunities and Considerations for Public Hospitals and Health Systems, National Association of Public Hospitals and Health Systems. (On file with the Senate Health Regulation Committee)
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[31] Agency for Health Care Administration, Centers for Medicare and Medicaid Services Special Terms and Conditions, Medicaid Reform Section 115 Demonstration, Part XV, Condition 105. Found at: <http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/waiver/pdfs/cms_special_terms_and_conditions.pdf> (Last visited January 15, 2010).

year 4 of the Medicaid reform demonstration[32] and the Legislature has not authorized expansion of Medicaid reform beyond the phase I counties: Broward, Duval, Baker, Clay, and Nassau.

In order for Florida to receive the full $1 billion federal LIP allocation, the Legislature included language in the General Appropriations Act (GAA)[33] for state fiscal year 2009-2010 that authorizes the Agency to apply for an amendment to the STC of the Florida Medicaid reform 1115 demonstration. The Agency staff has been in dialog with CMS over the STC #105 since July, 2009.[34] On November 25, 2009, the Agency submitted a formal request to CMS requesting STC #105 be amended to uncouple the statewide waiver expansion requirement from the additional $300 million LIP funds available to the state in demonstration year 5.[35] According to the language in the GAA, CMS has until January 31, 2010 to respond to the Medicaid reform waiver amendment request before the state withholds part of the LIP funding for the current fiscal year to cover LIP allocations for next fiscal year. As of January 15, 2010, the Agency has not received a response to the waiver amendment request.[36]

Medicaid Reform/LIP

As part of Medicaid reform, the LIP is scheduled to expire July 5, 2011, unless the Legislature authorizes the Agency to extend Medicaid reform or directs the Agency to apply for a new Medicaid 1115 waiver that includes a program similar to the LIP. During the 2010 legislative session, the Legislature will need to direct the Agency to renew, extend, or terminate the Medicaid reform waiver. The Agency has indicated that the Medicaid waiver renewal or extension application process takes approximately 6-8 months.[37] Medicaid waiver extension or renewal is subject to the CMS approval.

The STCs of the Medicaid Reform waiver allow Florida to suspend or terminate this demonstration in whole or in part at any time prior to the date of expiration. If Florida decides to phase-out the Medicaid reform demonstration, the state must notify the CMS in writing of the reason for the suspension or termination and the effective date of the suspension or termination. In the event of the suspension or termination of the Medicaid reform demonstration, Florida must notify the CMS in writing, at least 6 months prior to initiating phase out activities.[38]

Presumably, without the Medicaid reform waiver, the LIP would revert back to the UPL program. The LIP program is capped at $1 billion for each year of Medicaid reform, whereas, the UPL program is calculated annually and is usually subject to yearly inflation. Although the LIP is capped at $1 billion, the LIP program may still bring in more federal funds to Florida than the UPL program. In order to thoroughly compare and contrast the two programs, it is essential that the Legislature has accurate estimates of UPL program funding. Senate professional staff has repeatedly requested the UPL estimates from the Agency. To date, staff has not received any UPL data from the Agency.

DSH

Medicaid reform did not impact the DSH program in Florida. However, the federal health care reform debate has included proposals that decrease DSH payments to states. One of the focuses of federal health care reform is to substantially increase the number of people with health benefits through an individual health insurance mandate and expansion of state and federal health care coverage programs. Federal health care reform policy-makers predict that federal health care reform will substantially decrease the number of uninsured individuals. Since the DSH program was

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[32] Year 4 of the Medicaid reform demonstration runs through July 5, 2010.

[33] SB 2600

[34] Agency for Health Care Administration, Presentation to the Senate Health and Human Services Appropriations Committee, October 7, 2009. Found at: <http://ahca.myflorida.com/Medicaid/deputy_secretary/recent_presentations/florida_medicaid_updates_100709.pdf> (Last visited on January 15, 2010).

[35] See < http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/2009-12-02/III_fed_update_amended_letter_attachments.pdf>. (Last visited on January 15, 2010).

[36] Telephone conversation between the Agency staff and staff of the Health Regulation Committee on January 15, 2010.

[37] Meeting with Agency for Health Care Administration staff, October 12, 2009.

[38] Agency for Health Care Administration, Centers for Medicare and Medicaid Services Special Terms and Conditions, Medicaid Reform Section 115 Demonstration. Found at: <http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/waiver/pdfs/cms_special_terms_and_conditions.pdf> (Last visited January 15, 2010).

partially created to provide funding for uncompensated hospital care, as the number of uninsured individuals decreases, presumably there will be a decrease in uncompensated care, thus, decreasing the need for DSH payments.

The U.S. House of Representatives and the U.S. Senate have both passed separate health care reform bills that include cuts to DSH payments. Under the U.S. House of Representatives bill, DSH payments would be reduced by a total of $10 billion. The federal DSH reductions would be phased in over a 3 year period and would include a reduction of: $1.5 billion in FY 2017, $2.5 billion in FY 2018, and $6 billion in FY 2019.[39] [40] Under the U.S. Senate bill the federal DSH reductions would be directly linked to the state's uninsured rate beginning October 1, 2012. Once a state decreases its uninsured rate by at least 45 percent, its DSH allotment would decrease by 35 percent. The Senate bill would continue to reduce DSH allotments as the percentage of uninsured individuals in the state decreases.[41] The final outcome of federal health care reform is unknown at this time.

The DSH allocations for State Fiscal Year 2008/2009 were $231.6 million and for State Fiscal Year 2009-2010 were $260.6 million.

Physician Special Medicaid Payments

Currently, the special Medicaid payment for physicians program only authorizes payments for physicians providing services via fee-for-service. During the 2009 legislative session, there was a policy proposal to authorize supplemental payment to specialty physicians providing Medicaid services in managed care programs. Implementation of a policy of this kind is contingent on a Medicaid waiver or a state plan amendment.

SMP Allocations

The table below shows the aggregate allocations for physician SMP over the last two complete fiscal years.[42]

Entity	State Fiscal Year 06/07	State Fiscal Year 07/08
University of South Florida	6,771,401	7,969,083
University of Miami	35,654,377	37,867,801
University of Florida – Jacksonville	18,232,071	19,405,567
University of Florida - Gainesville	36,068,762	37,305,648

The Future of IGTs

The majority of the state portion of supplemental Medicaid payments is provided by IGT contributors. In fiscal year 2009-2010 over twenty-five counties contributed IGTs to draw down additional federal funds for supplemental Medicaid payment programs.[43] The table below includes the contributions for the top 8 IGT contributors.

Local Government/Special Taxing Authority	IGTs Contributed
Miami-Dade County	$294,138,329
Broward County – North/South Broward Hospital Districts	$199,946,887
Palm Beach County – Health Care District	$30,680,657
Volusia County – Halifax Hospital Medical Ctr. Taxing District	$28,381,703
Hillsborough County	$27,926,398
Duval County	$19,645,613
Pinellas County	$19,472,934
Sarasota County Public Hospital Board	$16,608,808

[39] Federal Funds Information for States, Issue Brief 10-01, Health Care Reform Moves Forward, Includes Big Changes to Medicaid, January 7, 2010.
[40] Federal fiscal year begins October 1 and ends on September 30 of the next calendar year.
[41] Federal Funds Information for States, Issue Brief 10-01, Health Care Reform Moves Forward, Includes Big Changes to Medicaid, January 7, 2010.
[42] Written documentation provided by the Agency for Health Care Administration Staff, October 2009.
[43] See http://ahca.myflorida.com/Medicaid/medicaid_reform/lip/2009-12-02/Ve_sfy_0910_funding.pdf (Last visited January 15, 2010).

The state has an interest in ensuring that sufficient IGT incentives exist, so counties will continue to provide dollars to support supplemental Medicaid payment programs. Without IGTs, the state would need to increase the general revenue appropriations in order to draw down the federal dollars.

Options and/or Recommendations

The Legislature should ensure that any future policy changes to the Medicaid program will not adversely impact the supplemental Medicaid payment programs in Florida. To this end, the Legislature should:

- Monitor federal health care reform, particularly as it pertains to the DSH program. If federal law decreases DSH allocations to the states at a time certain the Legislature will need to prepare for the impact in Florida. In addition, federal health care reform may affect other components of supplemental Medicaid payment programs in Florida.
- Direct the Agency to provide the Legislature with accurate UPL estimates. Currently there is no UPL program in Florida. However, the LIP is a component of the Medicaid reform pilot. Accurate UPL estimates will help the Legislature make informed decisions about the future of the Medicaid reform waiver including the LIP.
- Maintain incentives for counties to continue to contribute IGTs to the supplemental Medicaid payment programs. Any policy changes to the Medicaid program that would substantially change the supplemental Medicaid reimbursement methodology may adversely affect the incentives that certain counties have to contribute.